EDITORIAL RESEARCH REPORTS

1961
Vol. II

SOCIALIZED MEDICINE IN GREAT BRITAIN

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No. 6
Aug. 9

Editorial Research Reports
1156 Nineteenth Street, N.W.
Washington

SOCIALIZED MEDICINE IN GREAT BRITAIN

HEARINGS before the House Ways and Means Committee on President Kennedy's plan to finance health care of the aged through the Social Security system have laid the initial groundwork for action on the proposed legislation at the 1962 session of Congress.[1] The President's plan, outlined in a special message last Feb. 9, would provide specified benefits for "all persons aged 65 and over who are eligible for Social Security or Railroad Retirement benefits."

Benefits under the proposed legislation would be of four types, set forth as follows:

(1) In-patient hospital services up to 90 days in a single spell of illness, for all costs in excess of $10 a day for the first nine days (with a minimum of $20), and full costs for the remaining 81 days.

(2) Skilled nursing home services up to 180 days immediately after discharge from a hospital.

(3) Hospital out-patient clinic diagnostic services for all costs in excess of $20.

(4) Community visiting nurse services, and related home health services, for a limited period of time.

The program would be financed by increases in Social Security taxes on employers and employees and "would not place any burden on the general revenues."

A much more comprehensive plan of health insurance than that offered by President Kennedy, applicable to all persons covered by Social Security and to members of their immediate families, was proposed in 1949 by President Truman. Benefits, financed through Social Security but with contributions also from general revenues, would have included complete medical, dental and hospital care. Individuals would have had the right to choose their own

[1] The hearings opened July 24 and continued through Aug. 4. Bills to carry out the Kennedy proposals were introduced in the House by Rep. Cecil R. King (D Calif.) and in the Senate by Sen. Clinton P. Anderson (D N.M.) with Sens. Paul H. Douglas (D Ill.), Vance Hartke (D Ind.), Eugene J. McCarthy (D Minn.), Hubert H. Humphrey (D Minn.), Henry M. Jackson (D Wash.), Claiborne Pell (D R.I.) and Quentin N. Burdick (D N.D.) as co-sponsors.

physicians, while doctors, dentists, nurses and hospitals would have been free to participate in the program or to remain outside.[2] Strong opposition to the Truman proposal was voiced by medical, dental and hospital associations and by private companies and organizations offering health insurance. In the end, the 81st Congress took no action before its final adjournment on Jan. 2, 1951.

Opposition to Proposals as Socialized Medicine

President Kennedy insisted in his health care message of Feb. 9 that the program he proposed was "not a program of socialized medicine." It was, he said, "a program of prepayment of health costs with absolute freedom of choice [as to doctor and hospital] guaranteed." The President presumably made that reference because proposals for health insurance under federal auspices usually arouse opposition from some quarters on the ground that they constitute socialized medicine or would be an entering wedge for socialized medicine.

The Truman plan had been vigorously opposed on that ground by the American Medical Association and in a statement submitted to the Ways and Means Committee this Aug. 2, Dr. Leonard W. Larson, president of the A.M.A., said the Kennedy proposal "would provide socialized medicine for the aged"; in time the program "would become socialized medicine . . . for everyone." On the opening day of the hearings, July 24, Secretary of Health, Education and Welfare Abraham A. Ribicoff had accused the A.M.A. of using "a bogeyman of socialized medicine" to frighten people into opposing the administration plan for health care of the aged.

Whether or not a program for financing health care of the aged through Social Security may accurately be described as socialized medicine is to some extent a matter of individual opinion. Feelings on the question are apt to run deep. It is certain, therefore, that a great deal will be heard about socialized medicine before debate on the current Kennedy plan is concluded and Congress votes on it next year.

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[2] Several bills introduced by Democratic members of Congress in 1959 and 1960, notably a measure sponsored by Rep. Aime J. Forand (D R.I.), would have provided health care for the aged through Social Security. The Forand bill did not come to a vote in the House, but the Senate rejected a comparable proposal, 51-44, last Aug. 23. A bill signed by the President, Sept. 13, embodied the Eisenhower administration's plan for a federal-state system of medical benefits to the needy aged, financed in large part through federal grants to the states.

EXAMPLE OF SOCIALIZED MEDICINE IN GREAT BRITAIN

Socialized medicine may be defined broadly as a comprehensive program of medical care, available to the whole or to a great majority of the population of a country, and financed in large part by the state from general revenues. Such programs are now operating in nations as diverse in wealth and cultural background as Albania, Australia, Iceland, Iraq, Japan, Norway and the Soviet Union. But the program that has attracted most attention in the United States has been Great Britain's National Health Service, which entered its fourteenth year of operation on July 5. The British scheme, offering a broad range of low-cost medical services to everyone wishing to use them, may be taken as an illustration of the benefits and problems connected with a system of socialized medicine in an advanced industrial society.

Despite recurring complaints of financial hardship from doctors, faulty coordination in administration, and objections by the public to certain user charges, the National Health Service appears to command the support of most of the British public and of the British medical profession. The London medical weekly *Lancet*, taking stock on July 5, 1958, of the first 10 years of N.H.S., commented: "For our part we think the National Health Service one of the biggest improvements in the life of this country since the war. Thanks to very hard and intelligent work by a great many people, professional and lay, it has done much to better the conditions of medical care, and it has been an immense comfort to the public."

Development of British Health Service

THE British National Health Service, instituted in 1948 to provide complete medical and dental care for the British people, developed out of a number of public, quasi-public and private services previously available to different segments of the population.[3] Care by general practitioners had been furnished to certain groups of British workers since 1911 through national health insurance; public med-

[3] See "British National Health Service," *E.R.R.*, 1949 Vol. I, pp. 23-40.

ical officers provided free health care for indigent persons. Institutional care was given by voluntary hospitals, municipal hospitals, and public-assistance institutions. Special services, mainly under public auspices, had been set up to assist persons suffering from tuberculosis, venereal diseases or industrial diseases, to give maternity and child welfare aid, and to help persons in need of mental therapy.

Despite the variety of existing provisions for medical care, British health authorities had long been aware of gaps in the available services. Medical care under the National Health Insurance Act, for example, was limited to manual workers and low-paid white-collar workers. The health insurance system had been twice revised to take in more workers, but benefits were still limited to care by general practitioners and did not cover families of insured workers. A Medical Planning Commission, established in 1940 through the joint efforts of all the major medical organizations, concluded that there should be available to every individual all necessary health services, including those of general practitioners and specialists, in homes, doctors' offices and hospitals.

Planning for a comprehensive public health service was undertaken in 1941 as a part of the Churchill government's consideration of postwar reconstruction problems. Sir William (now Lord) Beveridge, who headed an interdepartmental committee on social insurance and allied services, asserted in 1942 that no satisfactory scheme for social security could be devised unless it were assumed that "comprehensive health and rehabilitation services for prevention and cure of disease and restoration of capacity for work" were to be made available to all members of the community. Both the government and the medical groups accepted this conclusion.

In 1944 the Churchill government made public a draft plan for a national health service. Two years later, under the Labor government of Clement Attlee, the National Health Service Act, authorizing complete health care without charge for all persons in England and Wales, became law. Similar services for the people of Scotland and Northern Ireland were authorized by the National Health Service (Scotland) Act in 1947 and the National Health Service (Northern Ireland) Act in 1948. All three acts became effective July 5, 1948.

Funds for the British system are drawn from four sources. About 15 per cent of the cost is met from social insurance contributions, 5 per cent from charges for various services, and 4 per cent from local funds; the remainder of the cost—more than 75 per cent—is met from general tax revenues. Patients and doctors are free to join the service or to stay out as they choose; participating doctors are remunerated solely on the basis of the number of patients on their lists.

Scope of Benefits Under British Health System

The National Health Service acts enabled any person—even persons neither employed nor self-employed and so not making regular contributions to the cost of the service—to avail himself of the following benefits as needed:

Care by general medical practitioners and specialists and by dentists and oculists.

Complete in-patient and out-patient hospital care, with treatment continuing during convalescence and rehabilitation.

Home nursing and domestic help when required by the illness of the homemaker.

All necessary drugs and appliances.

Most of these benefits were provided free of charge. However, special charges were made for private and semi-private accommodations in hospitals, for costly frames for glasses, and for certain other items.

Since the service began, the normal channel to all of the medical and hospital services has been the family doctor, selected by the patient from among doctors in his community who participate in the program. A doctor may refuse to accept a patient or may drop a patient already on his list; likewise, a patient may change doctors. In addition to furnishing office care and making home calls, the doctor refers the patient to a hospital when necessary. Arrangements for surgical or other specialist care are usually made by the hospital. A person seeking ophthalmic services for the first time must get his doctor to certify that his sight needs attention.

Except in rural areas, doctors' prescriptions are filled by chemists cooperating in the service. Hearing aids devised by the Medical Research Council are supplied at distribution centers to patients referred from hospital ear clinics. Anyone in need of dental care may consult any

participating dentist, who will give treatment and supply any needed dentures.

Administration of British Health Service

Administrative responsibility for the N.H.S. is vested in the Minister of Health, who is advised by a Central Health Services Council made up of the heads of the principal medical associations, representatives of the professions working in the service, and persons with experience in hospital management and in local public health activities. Also advising the minister is the Medical Practices Committee, which classifies localities according to number of doctors in relation to population and exercises certain powers to improve distribution of medical manpower.[4] General supervision of hospital and specialist services is in the hands of 15 regional boards, appointed by the Minister of Health after consultation with interested organizations. These boards in turn appoint the management committee of each local hospital. Each of the 15 hospital regions has 1½ million to 4½ million inhabitants. Wherever possible, hospital regions have been set up around teaching hospitals, in order to further medical research.[5]

The basic personal services in England and Wales are administered by 138 local executive councils. The councils, whose membership is half lay and half professional, contract with the doctors, dentists, and pharmacists, and make payments from funds allocated to them from the central pool. Advised by committees representing local practitioners, the councils receive complaints from the public and may take disciplinary action against persons under contract. The councils are responsible also for coordination of local health authorities with general practitioner services.

Some 146 local health authorities, which are the existing county and county borough councils, are responsible for maternity and child welfare, health visiting, home nursing, prevention of illness, and ambulance services. They are empowered to provide, equip and maintain health centers,

[4] Localities are classified as restricted ("over-doctored"), doubtful, or designated ("under-doctored"). Doctors going into practice for the first time or moving to another community must make application to the Medical Practices Committee. Applications to practice in over-doctored areas are almost always turned down. Dentists, oculists, etc., are not subject to restrictions on place of practice.

[5] Each of the 36 teaching hospitals, which provide facilities for undergraduate and postgraduate clinical instruction, is managed by its own board of governors. The latter boards are answerable only to the Minister of Health.

where general practitioners and specialists are to be available for consultation.

Introduction of Charges for Certain Services

The British government, concerned about the steadily rising cost of N.H.S., introduced charges for certain dental, pharmaceutical and ophthalmic services in the National Health Service Acts of 1951 and 1952. Moreover, the National Health Service Contributions Acts of 1957 and 1958 increased the weekly contributions to the cost of the service made by employees and employers.[6] One effect of the various acts was to reduce the national Exchequer's proportional share of N.H.S. costs by shifting a larger portion to persons using the service.

By the end of 1952, charges were in effect for prescription drugs and for dressings; for dentures and all dental treatments except clinical examinations of the mouth; for all spectacle lenses and frames; and for appliances such as surgical footwear and wigs.[7] All of these services, with the exception of expensive dentures and spectacle frames, originally had been supplied without charge. The 1952 act also doubled fees for private and semi-private hospital rooms. The revenue provided by the charges covered about 5 per cent of the gross annual cost of N.H.S. in the 1957-58 fiscal year; the Exchequer's share of 77 per cent was about 5½ per cent less than it had been in 1949-50, before the charges were introduced.

Prescription charges had been authorized in the National Health Service (Amendment) Act of 1949, although none actually were levied until 1952. The 1949 act also authorized recovery of medical and dental treatment costs from persons not ordinarily resident in Great Britain. Despite periodic complaints about foreigners "mooching" off the service,[8] the government seldom has forced non-residents to pay for N.H.S. treatment.

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[6] In 1948 the weekly N.H.S. contribution was 8½d. (10c) for an employed male worker and 1½d. (2c) for his employer. The 1958 act fixed the contribution for a male worker at 1s. 10½d. (26c) and for the employer at 5½d. (6c). Self-employed persons pay in a somewhat larger weekly contribution.

[7] The 1952 act levied a 1s. (14c) charge for each prescription regardless of the number of items prescribed (starting in 1956, 1s. was charged for each item). Nursing mothers and persons under 21 years of age were exempted from dental charges. Hospital in-patients were exempted from charges for spectacles. Three types of glasses were supplied without charge to children under 16 and to older children attending school.

[8] In answer to a question in the House of Commons, July 24, the Minister of Health said that members of the Leningrad State Kirov Ballet had cost the health service £100 ($280) for dental services during their recent stay in London.

The charges introduced in 1951 and 1952 do not appear to have deterred patients from using the service. For example, more than 207 million prescriptions were dispensed in 1957, an increase of five million over 1949. On the other hand, the number of dentures and spectacles supplied in 1959 and 1960 was only half the number supplied in 1949 and 1950, but exceptionally heavy demand for these items had been expected in the early years of the service because of the known backlog of need.

General Improvement in British Health, 1949-59

The over-all health of the British people has improved markedly since the start of the national service. Between 1949 and 1959, for example, the infant mortality rate fell from 33.9 to 23 per 1,000 births, the maternal mortality rate from 1.02 to 0.47 per 1,000 births, and the number of tuberculosis patients from 552 to 107 per million persons. Diphtheria, which claimed 3,268 lives in 1941, was responsible for only eight deaths in 1958. Reports of school medical officers show that British school children today are generally taller, healthier, and of sturdier physique than those of 10 years ago.[9]

These improvements, many persons point out, have been due in part to rising living standards, better diets, and advances by medical science in the prevention and treatment of certain diseases. Yet the health service, by sharply reducing the individual's medical costs, has in effect raised his living standard, and N.H.S. has made medical care more readily available by controlling the distribution of general practitioners. Dr. G. E. Godber, deputy medical officer of the Ministry of Health, reported in the *Lancet*, July 5, 1958, that in 1956 slightly more than one-fifth of the population lived in "under-doctored" areas (most of them in the industrial North), compared with almost one-half in 1952. By 1958, less than one-twentieth of the population lived in "over-doctored" areas.

While patients appear to be satisfied with the quality of medical care under N.H.S., they often complain of long waits in doctors' offices before treatment can be obtained. Hospital accommodations also are in great demand. Emergency cases are admitted promptly, but persons desiring elective surgery, such as correction of hernia or varicose

[9] British Information Services, *Health Services in Britain* (1961), p. 1.

veins, often must wait for periods of up to a year. A wait of five months for a tonsilectomy is not uncommon. At the end of 1959, the hospital waiting list in Great Britain totaled 476,000 persons.

Present Status of the British Program

THE MACMILLAN GOVERNMENT announced further increases in health service charges and contributions last Feb. 1.[10] It estimated later than the additional revenue would reduce the Exchequer's contribution to the program by £30.7 million ($86 million) in the 1961-62 fiscal year. Minister of Health Enoch Powell was greeted by cries of "shame," "scandalous," "disgraceful," and "Scrooge" from Labor party members when he outlined the new fee schedule in the House of Commons. Laborite Kenneth Robinson said: "This comprehensive list of charges represents in our view the biggest single assault on the whole principle underlying the National Health Service since it was conceived, and a very serious inroad into the welfare state."

Reaction to New Boost in Health Service Fees

The new charges for medical services were condemned also outside of Parliament. The British Medical Association said, Feb. 1, that "As an association we have opposed prescription charges since they were introduced, for we believe they create a financial barrier at the time of treatment between the patient and the treatment he may require." Factory workers in Manchester staged a one-day strike in protest against the increases, while resolutions condemning the government's action were adopted at special meetings in plants in other parts of the country. Conservatives defended the government's course by asserting that as wages had doubled since the start of the service,[11]

[10] Contributions were raised to 2s. 8½d. (38c) for an employed male worker and to 7½d. (10c) for his employer. Charges for dentures were increased by 5s. (70c) to 15s. ($2.10), depending on type. The most expensive dentures now cost £5 ($14). Private and semi-private hospital room fees again were doubled, to 24s. ($3.36) and 12s. ($1.68) a day, respectively. Charges for spectacle lenses were increased by 5s. a pair, with higher charges for bifocal and multifocal lenses. An ordinary pair of lenses now costs £1 5s. ($3.50). The prescription charge was raised to 2s. (28c) per item. The prescription and hospital room charges went into effect on March 1, and the new denture and lens charges and contributions increases on July 1.

[11] The average weekly wage of a male worker in Great Britain is now £14 10s. 8d. ($40.70), as against £7 10s. ($21) a decade ago.

it was "fair and reasonable" that charges also should be increased.

Proposal to Introduce Ability-to-Pay Principle

The government's practice, now as in the past, has been to impose health service charges and contributions on a flat basis without regard to amount of personal income. Although the charges are nominal, for the most part, they are said to be high enough at present to constitute an unfair burden on the poor. The London *Times* asserted, April 13, that the new charges "do act as a small but by no means negligible deterrent" to use of the service, and that indigent persons were reluctant to seek help from the National Assistance Board in meeting their medical expenses. The secretary of the National Pharmaceutical Union said, March 23, that a chemist in a low-income section of Liverpool had reported a 60 per cent drop in the number of prescriptions dispensed in the first 10 days under the 2s. charge. "Mr. Powell's measures are a once-for-all budgetary operation rather than a carefully thought-out reform," the *Economist* declared on Feb. 4, "and in future years he will have to return to the charge again."

The *Economist* proposed a revised system of charges and contributions, designed to bear most heavily on the income groups best able to pay and thus afford some relief for persons less able to pay. National health insurance contributions, for example, could be assessed as a percentage of earnings. A further increase in prescription charges, in the opinion of the *Economist*, would encourage persons better off financially to buy medicines for minor ailments directly from a chemist instead of queuing up at the doctor's office for prescriptions.

Charges for dental treatment also were said to be in need of revision. The present fee of £1 ($2.80) covers standard dental treatment—that is, filling and extraction of teeth—given after a preliminary examination. Thus, a person who visits the dentist regularly pays more in charges than a person who stays away until extensive treatment is required, even though the total amount of work done may be the same for both.

The British government has sought to limit health service costs ever since Chancellor of the Exchequer Sir Stafford Cripps proposed, March 14, 1950, that the £393 million

($1.1 billion) N.H.S. budget estimate for the 1950-51 fiscal year be made a permanent annual ceiling. Inflation has pushed succeeding budgets far beyond that figure; the 1961-62 estimate is £806 million ($2.2 billion), of which about £600 million ($1.7 billion) is to be paid by the Exchequer. However, in terms of percentage of the gross national product, the annual cost of N.H.S. has varied only slightly since 1949, never going below 3.5 per cent or much above 4 per cent. The service currently accounts for about one-fourth of total annual expenditures on social services—a sum comparable to that spent on education.

Problem of Curbing Rise in Prescription Costs

The steadily rising cost of the pharmaceutical service has been of particular concern to the government. Because of higher drug prices, the average cost of a prescription has risen from 2s. 8½d. (33c) in 1949 to about 7s. 4d. ($1.03) at present. Moreover, prescriptions are now being dispensed at a rate of about 250 million annually; 202 million were dispensed in 1949.

As early as November 1949, Aneurin Bevan, then Minister of Health, referred to the "ceaseless cascade of medicine which is pouring down British throats." Teams of investigators sent out by the British Medical Association in 1960 reported that many Britons regularly consume drugs, not because they need them, but because they feel their health will suffer if they don't. A study of the health service published in Great Britain in 1952 declared:

> The excessive demand on doctors for medicines is in part a revelation of the extent to which people had been doctoring themselves with medicines: a proof of the need for medical guidance *away* from drugs and not *to* them. It is sometimes thought that the high rate of demand is a peak and will find a natural lower level. This is not so: in this matter the habit is established and grows upon itself.[12]

It was discovered early in the life of the service that doctors with a heavy patient load often prescribed drugs in larger quantities than needed, in the hope of postponing the patient's next visit. Furthermore, new and expensive medicines sometimes were prescribed when less costly preparations would have served the purpose. In some instances, patients demanded drugs for which they had no real need

[12] James Stirling Ross, *The National Health Service in Great Britain* (1952), p. 246.

and threatened to change doctors if they were not given prescriptions. A joint committee appointed by the Central Health Services Council appealed to doctors in January 1950 to desist from excessive drug therapy. The Minister of Health declared in December 1950 that the responsibility for prescribing rested solely with the doctor, and that any doctor who refused importunate demands for drugs would have his full support.

Increases in the Pay of Doctors and Dentists

General practitioners threatened in 1951, and again in 1957, to withdraw from N.H.S. if the government did not meet their demands for higher remuneration. Both times the doctors insisted that they were entitled to larger compensation because of increases in the cost of living and in the earnings of persons in other professions. In December 1951, the government submitted the doctors' demands to Justice Harold Danckwerts of the High Court of Justice for arbitration. Justice Danckwerts proposed pay increases, later approved by Parliament, averaging £500 ($1,400) a year and retroactive to 1948.

A Royal Commission on Doctors' and Dentists' Remuneration, appointed in March 1957 in response to the doctors' second threat to pull out of N.H.S., recommended, Feb. 18, 1960, further increases averaging £550 ($1,540) for general practitioners, as well as salary increases for specialists and dentists working in hospitals.[13] The proposed increases would raise the average income of general practitioners from £1,975 ($5,539) to £2,425 ($6,790). The commission's recommendations were accepted by the British Medical Association on Sept. 28, 1960, and went into effect this year.

A general practitioner in the health service is remunerated on the basis of a capitation payment of 19s. 6d. ($2.73) a year for each patient registered as under his care; an additional 14s. ($1.96) is paid for each patient on his list in excess of 400 and up to 1,600. The present average list numbers about 2,200 patients. Under the capitation scheme, doctors' earnings may range from £390 ($1,092) for a list of 400 patients to £4,252 10s. ($11,906) for a list with the maximum allowed number of 3,500.[14] In addition

[13] The commission did not recommend increases for dentists in general practice; their compensation was considered adequate.

[14] The 3,500 patient limit for single practice was established as a result of the Danckwerts award in 1952. Previously, doctors were allowed to have as many as 4,000 patients.

to capitation payments, doctors may receive mileage allowances for visiting patients in rural areas. They are entitled also to payments for special services, such as treatment of temporary residents and emergency patients, administration of anesthetics, training of assistants, maternity work, hospital duties, and dispensing their own prescriptions. "Initial practice allowances," paid on a descending scale over four years, are available to doctors setting up practice in "under-doctored" areas.

Dentists in the service are compensated on a fee basis, as in private practice, with the government instead of the patient paying the bill. Medical and dental specialists working full time in hospitals receive annual salaries based on tenure and experience. Special distinction grants are made to specialists as a reward for outstanding work.[15]

The system for remuneration of health service practitioners was developed from the recommendations of three committees set up late in 1946 under the chairmanship of Sir Will Spens, master of Corpus Christi College, Cambridge University. The committees undertook to survey the incomes of general practitioners, specialists and dentists, respectively, and to recommend levels of income for health service doctors which would adequately reward professional training and continue to attract young people to the professions.

The committees ascertained what they thought practitioners should have earned in 1939, but they "left to others the problems of the necessary adjustment to present conditions." That adjustment, they observed, "should have direct regard, not only to estimates of the change in the value of money, but to the increases which have in fact taken place since 1939 in incomes in other professions."

Extent of Participation in the Health Service

The great majority of British doctors and of the British people now participate in the National Health Service.[16] More than 20,000 general practitioners in England and Wales, and nearly 2,500 practitioners in Scotland, were in the service last March 1. Only between 500 and 600 doc-

[15] The Royal Commission recommended in 1960 that funds be set aside for similar awards to general practitioners who show unusual merit.

[16] The figures used in this section are taken from *Health Services in Britain*, published in March 1961 by British Information Services.

tors in England and Wales have remained exclusively in private practice.[17]

Of some 11,200 dentists in England and Wales available for general practice, about 10,300 are in the service, and virtually all of the 1,300 dentists in Scotland are participants. Other participants include 6,900 opticians and ophthalmic medical practitioners in England and Wales, and nearly 1,000 in Scotland, and around 16,000 chemists in England and Wales and 2,800 in Scotland. More than 3,000 hospitals in Great Britain are under N.H.S. administration.

About 97 per cent of the British population uses the health service. The remaining 3 per cent consists mainly of well-to-do and elderly persons who want more individual attention than can be afforded under N.H.S. Public participation is determined from the total number of names carried on doctors' lists of patients. However, this total tends to reflect a slightly higher degree of participation than actually exists, for names of persons who change doctors or move from one community to another may appear on two or more lists.

Problems Facing National Health Service

ALTHOUGH the National Health Service has been criticized in Great Britain for its high costs and administrative flaws, not even its severest critics have proposed return to a system of private medicine. Reform of the service, if it were undertaken, would most likely consist of minor adjustments in charges and in the administrative structure. Sir Arthur Porritt, then president of the British Medical Association, recommended on June 21, 1960, that an independent body—a sort of medical counterpart of the British Broadcasting Corporation—be created to administer the National Health Service. Its budget would be approved by the government, but it would be operated by doctors and expert laymen, not civil servants. While few people want to abolish the service, Sir Arthur remarked that "There must be a vast number who would like to

[17] Health service practitioners may take private patients if they wish.

see infinitely less red tape with more responsibility on the part of both doctor and patient."

Sir Arthur's views were not shared by the government. Four years earlier, on Jan. 25, 1956, a governmental committee[18] which had studied the cost of N.H.S. reported: "It is very true that [N.H.S.] suffers from many defects as a result of the division of functions between the different authorities, and that there is a lack of coordination between the different parts of the service. But . . . the service works much better in practice than it does on paper." The committee said it had found no evidence of extravagance in the use of money or manpower, nor any indication that the quality of service performed by physicians had deteriorated.

The committee recommended that funds for some parts of the service might well be increased. It suggested, for example, that £30 million ($84 million) a year be devoted to hospital construction in each of the ensuing seven years. The 1961-62 budget estimate includes £34.7 million ($97.1 million) for this purpose, but only £27.7 million ($77.6 million) was made available in the previous fiscal year.

Need for Construction of Additional Hospitals

Hospital construction has been severely limited under the National Health Service. Only one hospital, in fact, has been built in Great Britain since World War II, although more than 100 major hospital construction projects are reported to be under way now, or at least in the planning stage. Most of these projects, however, consist only of extensions or alterations of existing structures.

Between 1949 and 1957, the total number of attended hospital beds in England and Wales rose from 448,057 to 477,290, while the average daily number of occupied beds increased from 397,570 to 420,173. This has meant a daily occupancy average of 80 to 90 per cent of capacity, a situation that "suggests a serious shortage of facilities relative to demand; anything over [90 per cent occupancy] means overcrowding into the bargain." [19] Since the 80 to

[18] The Committee of Enquiry into the Cost of the National Health Service, set up in 1953 under the chairmanship of C. W. Guillebaud, a Cambridge University economist.

[19] Harry Eckstein, *The English Health Service* (1958), p. 238.

90 per cent average refers to the country as a whole, it may be assumed that many hospitals—if not all—have experienced an occupancy in excess of 90 per cent at one time or another.

One way to relieve the strain on hospital accommodations would be to transfer some patients, such as elderly persons, chronic invalids, and maternity cases, to their homes or to special institutions where they could be cared for by general practitioners and attended by nurses supplied by local health authorities. It has been estimated that about 60 per cent of elderly patients and chronic invalids in hospitals could be so transferred without detriment to their condition.

The high rate of hospital occupancy has adversely affected medical research by limiting the use for research of such overworked facilities as laboratories. And the hospital nursing staff, while it has increased over the past dozen years, still falls short of the need, particularly in mental institutions.

Lack of Coordination in Administration of Program

Perhaps the most frequently voiced complaint is that the various parts of the National Health Service do not operate as an integrated whole. The *Economist*, July 5, 1958, asserted:

> Because of the tripartite structure [of N.H.S.] its three main branches—hospitals, the general medical services and the local authority services—are so cut off from each other that each thinks the job done when it has handed a patient over to the care of one of the others. Each one's costs are examined in isolation; for instance, the rise in the cost of the pharmaceutical service is looked at askance without anyone trying to find out whether there has been any consequential saving in hospital costs.

This lack of coordination is ascribed primarily to failure of the health center program, once described by the Ministry of Health as the "key feature" of the National Health Service. The planners of N.H.S. intended health centers to be the means of integrating all three branches of the service on the local level. Local health authorities were to provide, equip, and maintain the centers, in which some or all of the following benefits would be available: family doctor, dental, and pharmaceutical services; clinical and health education facilities, furnished by the local authorities; and hospital specialist services.

A few scattered health centers have been established, but a shortage of capital funds and a lack of enthusiasm for the centers on the part of doctors have kept the program from moving beyond the experimental stage. Instead, the government has encouraged family doctors to enter into group practice. Interest-free loans are available to general practitioners who wish to acquire premises for a group practice, which normally includes three to six doctors.[20] Group practice enables doctors to share costs and equalize working hours, but because it does not attempt to provide a full range of medical care extending into the hospitals, it is not regarded as a satisfactory substitute for a health center.

It had been hoped that the health service would promote closer cooperation between teaching and non-teaching hospitals, with the aim of injecting the teaching spirit into the whole hospital system. This has not happened. Teaching hospitals are managed by their own boards of governors, while general hospitals are managed by regional hospital boards, and there appears to have been little or no liaison between the two types of governing bodies. In effect, therefore, separation of teaching and non-teaching institutions has continued as before the inception of N.H.S., when teaching was almost exclusively the province of voluntary rather than public hospitals.[21]

Costs of National Health Service in the Future

From the earliest days of the National Health Service, the British government has been concerned about controlling the cost of the program without limiting the scope of health benefits. It may soon have to decide whether to increase the government's contribution to the cost of the program, to raise employer and employee contributions and charges for services once more, or to limit the services provided. None of these alternatives would be politically popular—in fact, any might prove disastrous to the party in power—but eventual choice of one or another of them, or a combination, seems inevitable.

D. S. Lees, writing in the London *Times* of March 22, pointed out that expenditures for medical care in the United

[20] Since 1952, the government has set aside £100,000 ($280,000) a year for loans to doctors going into group practice.

[21] Harry Eckstein, *op. cit.*, p. 184.

States, taken as a ratio of the gross national product, increased from 4.5 per cent in 1949 to 5.5 per cent in 1959.[22] In the same period, the relationship of comparable British expenditures to the gross national product remained almost constant, fluctuating between 3.5 per cent and slightly more than 4 per cent. Because the United States "sets a natural pattern for countries with high and growing levels of wealth," Lees observed, it cannot be assumed that health care spending in Great Britain, whose economy also has been expanding, will remain a constant proportion of the gross national product. Furthermore, it has been demonstrated that medical care is a commodity with a "high-income elasticity of demand," that is, as incomes rise demand will rise in greater proportion.

[22] Personal expenditures as well as spending by local, state and federal governments included.